# House of Representatives

General Assembly

**File No. 274**

***February Session, 2010***

Substitute House Bill No. 5303

*House of Representatives, April 1, 2010*

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

## *AN ACT REQUIRING REPORTING OF CERTAIN HEALTH INSURANCE CLAIMS DENIAL DATA.*

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-478c of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

(a) On or before May first of each year, each managed care organization shall submit to the commissioner:

(1) A report on its quality assurance plan that includes, but is not limited to, information on complaints related to providers and quality of care, on decisions related to patient requests for coverage and on prior authorization statistics. Statistical information shall be submitted in a manner permitting comparison across plans and shall include, but not be limited to: (A) The ratio of the number of complaints received to the number of enrollees; (B) a summary of the complaints received

related to providers and delivery of care or services and the action taken on the complaint; (C) the ratio of the number of prior authorizations denied to the number of prior authorizations requested; (D) the number of utilization review determinations made by or on behalf of a managed care organization not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure; (E) the percentage of those employers or groups that renew their contracts within the previous twelve months; and (F) notwithstanding the provisions of this subsection, on or before July **[**1, 1998, and annually thereafter**]** first of each year, all data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS). If an organization does not provide information for the National Committee for Quality Assurance for its Health Plan Employer Data and Information Set, then it shall provide such other equivalent data as the commissioner may require by regulations adopted in accordance with the provisions of chapter 54. The commissioner shall find that the requirements of this subdivision have been met if the managed care plan has received a one-year or higher level of accreditation by the National Committee for Quality Assurance and has submitted the Health Plan Employee Data Information Set data required by subparagraph (F) of this subdivision.

(2) A model contract that contains the provisions currently in force in contracts between the managed care organization and preferred provider networks in this state, and the managed care organization and participating providers in this state and, upon the commissioner's request, a copy of any individual contracts between such parties, provided the contract may withhold or redact proprietary fee schedule information.

(3) A written statement of the types of financial arrangements or contractual provisions that the managed care organization has with hospitals, utilization review companies, physicians, preferred provider networks and any other health care providers including, but not limited to, compensation based on a fee-for-service arrangement, a

risk-sharing arrangement or a capitated risk arrangement.

(4) Such information as the commissioner deems necessary to complete the consumer report card required pursuant to section 38a-478*l*, as amended by this act. Such information may include, but need not be limited to: (A) The organization's characteristics, including its model, its profit or nonprofit status, its address and telephone number, the length of time it has been licensed in this and any other state, its number of enrollees and whether it has received any national or regional accreditation; (B) a summary of the information required by subdivision (3) of this section, including any change in a plan's rates over the prior three years, its medical loss ratio, as defined in subsection (b) of section 38a-478*l*, as amended by this act, how it compensates health care providers and its premium level; (C) a description of services, the number of primary care physicians and specialists, the number and nature of participating preferred provider networks and the distribution and number of hospitals, by county; (D) utilization review information, including the name or source of any established medical protocols and the utilization review standards; (E) medical management information, including the provider-to-patient ratio by primary care provider and speciality care provider, the percentage of primary and speciality care providers who are board certified, and how the medical protocols incorporate input as required in section 38a-478e; (F) the quality assurance information required to be submitted under the provisions of subdivision (1) of subsection (a) of this section; (G) the status of the organization's compliance with the reporting requirements of this section; (H) whether the organization markets to individuals and Medicare recipients; (I) the number of hospital days per thousand enrollees; and (J) the average length of hospital stays for specific procedures, as may be requested by the commissioner.

(5) A summary of the procedures used by managed care organizations to credential providers.

(6) A report on claims denial data for lives covered in the state for

the prior calendar year, in a format prescribed by the commissioner, that includes: (A) The total number of claims received; (B) the total number of claims denied; (C) the total number of denials that were appealed; (D) the total number of denials that were reversed upon appeal; (E) (i) the reasons for the denials, including, but not limited to, "not a covered benefit", "not medically necessary" and "not an eligible enrollee", (ii) the total number of times each reason was used, and (iii) the percentage of the total number of denials each reason was used; and (F) other information the commissioner deems necessary.

(b) The information required pursuant to subsection (a) of this section shall be consistent with the data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS).

(c) The commissioner may accept electronic filing for any of the requirements under this section.

(d) No managed care organization shall be liable for a claim arising out of the submission of any information concerning complaints concerning providers, provided the managed care organization submitted the information in good faith.

(e) The information required under subdivision (6) of subsection (a) of this section shall be posted on the Insurance Department's Internet web site.

Sec. 2. Section 38a-478*l* of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2011*):

(a) Not later than October fifteenth of each year, the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall develop and distribute a consumer report card on all managed care organizations. The commissioner shall develop the consumer report card in a manner permitting consumer comparison across organizations.

(b) The consumer report card shall be known as the "Consumer Report Card on Health Insurance Carriers in Connecticut" and shall include (1) all health care centers licensed pursuant to chapter 698a, (2) the fifteen largest licensed health insurers that use provider networks and that are not included in subdivision (1) of this subsection, (3) the medical loss ratio of each such health care center or licensed health insurer, (4) the information required under subdivision (6) of subsection (a) of section 38a-478c, as amended by this act, and **[**(4)**]** (5) information concerning mental health services, as specified in subsection (c) of this section. The insurers selected pursuant to subdivision (2) of this subsection shall be selected on the basis of Connecticut direct written health premiums from such network plans. For the purposes of this section and sections 38a-477c, 38a-478c, as amended by this act, and 38a-478g, "medical loss ratio" means the ratio of incurred claims to earned premiums for the prior calendar year for managed care plans issued in the state. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss coverage, reinsurance, enrollee educational programs or other cost containment programs or features.

(c) With respect to mental health services, the consumer report card shall include information or measures with respect to the percentage of enrollees receiving mental health services, utilization of mental health and chemical dependence services, inpatient and outpatient admissions, discharge rates and average lengths of stay. Such data shall be collected in a manner consistent with the National Committee for Quality Assurance Health Plan Employer Data and Information Set (HEDIS) measures.

(d) The commissioner shall test market a draft of the consumer report card prior to its publication and distribution. As a result of such test marketing, the commissioner may make any necessary modification to its form or substance. The Insurance Department shall prominently display a link to the consumer report card on the department's Internet web site.

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *July 1, 2010* | 38a-478c |
| Sec. 2 | *January 1, 2011* | 38a-478*l* |

***Statement of Legislative Commissioners:***

In section 1(e), after "web site", "and shall be included in the consumer report card required pursuant to section 38a-478*l*, as amended by this act" was deleted as redundant, and in section 2(b)(4), "of subsection (a)" was inserted after "subdivision (6)" for accuracy.

***INS*** *Joint Favorable Subst.-LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

## *OFA Fiscal Note*

***State Impact:*** None

***Municipal Impact:*** None

### *Explanation*

The bill, which requires managed care organizations to report certain information to the Department of Insurance (DOI) for inclusion in DOI's consumer report card and website, does not result in a fiscal impact.

### *The Out Years*

***State Impact:*** None

***Municipal Impact:*** None

**OLR Bill Analysis**

**sHB 5303**

***AN ACT REQUIRING REPORTING OF CERTAIN HEALTH INSURANCE CLAIMS DENIAL DATA.***

## SUMMARY:

This bill adds claims denial data for the prior calendar year to the information that managed care organizations (MCOs) must report to the insurance commissioner annually by May 1. (MCOs include insurers, HMOs, hospital or medical service corporations, or other organizations issuing managed care plans in Connecticut.)

The bill requires the commissioner to post the claims denial information on the Insurance Department's website and include the data in the Consumer Report Card on Health Insurance Carriers in Connecticut, which the department publishes annually by October 15.

The bill makes technical and conforming changes.

EFFECTIVE DATE: July 1, 2010, except the consumer report card provision is effective January 1, 2011.

## CLAIMS DENIAL DATA REPORTING

The bill requires MCOs to report claims denial data to the insurance commissioner annually by May 1, in a format the commissioner prescribes. The data is for the prior calendar year and must relate to Connecticut residents covered by managed care plans.

The data must include the number of (1) claims received, (2) claims denied, (3) denials that were appealed, and (4) denials that were reversed on appeal. The data must also include (1) the reasons for the denials, including "not a covered benefit," "not medically necessary," and "not an eligible enrollee"; (2) the number and percentage of times

each reason was used; and (3) other information the commissioner deems necessary.

## COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 17 Nay 2 (03/16/2010)